

FINAL OPPS UPDATES FOR CY 2010

In the November 20, 2009 **Federal Register**, the Centers for Medicare and Medicaid Services (CMS) finalized changes to the hospital APC-based outpatient prospective payment system (OPPS) for services provided on or after January 1, 2010. This final rule implements applicable statutory requirements as well as changes arising out of Medicare's continued experience with the APC payment system. Updates include changes to APC definitions and the conversion factor, APC weights, and facility wage indices. This final rule also discusses new benefits available to Medicare beneficiaries and again touches on physician supervision in the hospital outpatient setting. Changes from the OPPS final rule and other related OPPS updates for calendar year (CY) 2010 are summarized below.

Note: The November 20, 2009 final rule also includes changes to Medicare's Ambulatory Surgery Center (ASC) Prospective Payment System for 2010. These changes are documented in a separate Ingenix Industry Insight.

1. **Composite APCs:** The APC panel recommended that CMS evaluate the implications of creating a composite APC for cardiac resynchronization therapy with a defibrillator or pacemaker. The agency agreed to this evaluation, but is not proposing to create any new composite APCs for 2010. Established composite APC policies for extended assessment and management, LDR prostate brachytherapy, cardiac electrophysiologic evaluation and ablation, mental health services, and multiple imaging services, will be maintained in 2010. Changes were made to the multiple imaging APCs to correlate to 2010 CPT changes. CPT code 0066T, Computed tomographic (CT) colonography (ie, virtual colonoscopy); diagnostic has been replaced with two new CPT codes, 74261, Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material will group to 8005 or 8006 and 74262, Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed groups to APC 8006.
2. **Conditional Packaging:** There are no changes to conditionally packaged services for CY 2010.
3. **APC Group Assignments:** CMS is required to annually review and revise the APC groups for changes in medical practice, changes in technology, and the addition of new services. This review is conducted in consultation with an outside advisory panel. In addition, CMS ensures, with certain exceptions, that services within a single APC meet the "two-times rule". This rule requires that the median cost of the most expensive item or service within a group cannot be more than two times greater than the median cost of the least expensive item or service within the same group. APC revisions for 2010 conform, in general, to this statutory framework. CMS is making the following changes and APC reassignments:
 - a.) CPT code 63685, Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling, is reassigned to APC 0039 and APC 0222 has been deleted. The new title for APC 0315 is Level II Implantation of Neurostimulator Generator.
 - b.) CPT code 27446, Arthroplasty, knee, condyle and plateau; medial OR lateral compartment, is reassigned to APC 0425. APC 0681 has been deleted. APC 0425 has been

retitled Level II Arthroplasty or Implantation with Prosthesis. The median costs of the procedures assigned to APC 0425 Level II Arthroplasty or Implantation with Prosthesis and APC 0681 Knee Arthroplasty are sufficiently similar to warrant combining these two APCs into one APC.

3. **Recalibration of APC Weights:** Final 2010 APC relative payments are based upon final adjudicated hospital outpatient claims for services furnished on or after January 1, 2008, and before January 1, 2009. After eliminating claims for services not paid under OPSS or not appropriate for use, CMS had approximately 58 million whole claims to be used to set the final OPSS APC relative weights for 2010. APC relative weights for 2010 continue to be based on the median hospital costs for services in the APC groups. For the final rule, APC median costs have been based on claims for services furnished in calendar year 2008 and processed before January 1, 2009.

CMS scaled all the relative payment weights to APC 0606 Level III Hospital Clinic Visit because it is one of the most frequently performed services in the hospital outpatient setting. APC 0606 was assigned a relative payment weight of 1.00, and the median cost for each APC was divided by the median cost for APC 0606 to derive the relative payment weight for each APC.

4. **Conversion Factor Update:** Regulations mandate that the 2010 OPSS update be equal to the hospital inpatient market basket percentage increase applicable to hospital discharges. The final hospital market basket increase for fiscal year (FY) 2010 published in the IPPS final rule on August 27, 2009, was 2.1 percent. The OPSS final conversion factor for 2010 OPSS was set by increasing the 2009 conversion factor of \$66.059 by 2.1 percent. Hospitals that fail to meet the reporting requirements of the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) are subject to a reduction of 2.0 percentage points from the market basket update to the conversion factor.

The final market basket increase update factor of 2.1 percent for 2010, the required wage index and rural budget neutrality adjustment of approximately 0.9997, and the adjustment of 0.03 percent for the difference in the pass-through set-aside result in a final standard OPSS conversion factor for 2010 of \$67.406.

Hospitals that fail to meet the requirements of the HOP QDRP for the full 2010 payment update receive a reduced market basket increase update factor of 0.1 percent and all other adjustments. Hospitals that fail to meet the quality reporting requirements will use a conversion factor of \$66.086.

5. **Wage Index Changes:** Since the inception of the OPSS, CMS policy has been to wage adjust 60 percent of the OPSS payment. The final 2010 OPSS continues this policy. As in prior years, CMS will to adopt the final IPPS wage indices for OPSS and extend these wage indices to all hospitals that participate in OPSS.

In 2010, non-IPPS hospitals will continue to qualify for the out-migration adjustment if they are located in a section 505 out-migration county (non-IPPS hospitals cannot reclassify).

6. **Payments to Certain Rural Hospitals:** Effective for services provided on or after January 1, 2010, rural hospitals and sole community hospitals (SCHs), including essential access community hospitals having 100 or fewer beds will no longer be eligible for transitional outpatient payments. For the 2010, CMS continues the policy of a budget neutral 7.1 percent payment adjustment for rural SCHs, including EACHs, for all services and procedures paid under OPSS, excluding separately payable drugs and biologicals, devices

paid under the pass-through payment policy, and items paid at charges reduced to costs.

7. **Outlier Payment Changes:** For hospitals in CY 2010, CMS continues to set aside one percent of aggregate total payments under OPSS for outlier payments. For hospital claims, CMS has set the 2010 outlier threshold so that outlier payments would be triggered when the cost of furnishing a service or procedure by a hospital exceeds a variable threshold, calculated as 1.75 times the APC payment amount for that service, and also exceeds the APC payment rate plus a \$2,175 fixed-dollar threshold. For eligible line items, outlier payment will be 50 percent of the amount by which the cost exceeds the variable threshold.

CMS sets different outlier thresholds for community mental health centers (CMHC) due to the significant differences in charges between the two types of facilities. For 2010, if a CMHC's costs for mental health services, paid under either APC 0172 or APC 0173, exceed 3.40 times the payment for those services, the outlier payment would be calculated as 50 percent of the amount by which the cost exceeds 3.40 times the payment rate. The portion of total OPSS payments being allocated for CMHC outliers is 0.0002.

In the 2009 OPSS/ASC final rule, CMS adopted a policy that would reconcile hospital or CMHC outlier payments at cost report settlement for services furnished during cost reporting periods beginning in 2010. OPSS outlier reconciliation thresholds are provided in section 10.7.2.1 of Chapter 4 of the Medicare Claims Processing Manual (Pub. 100-4). The reconciliation thresholds are reevaluated annually, and modified if necessary. When the cost report is settled, reconciliation of outlier payments will be based on the overall CCR, calculated as the ratio of costs and charges computed from the cost report at the time the cost report coinciding with the service dates is settled.

7. **Transitional Pass-Through Devices:** There are no current transitional pass-through device categories. CMS will continue the existing policy of establishing new categories in any quarter when the agency determines that the criteria for granting pass-through status for a device category are met. If CMS determines that claims data contain a sufficient number of claims with identifiable costs associated with the new category of devices in any APC with which it is billed, it will establish an offset amount greater than \$0 and reduce the transitional pass-through payment for the device by the related procedural APC offset amount. If a device offset amount greater than \$0 is appropriate for any new category created, the offset amount will be announced in the program transmittal that announces the new category.
8. **Implantable Biologicals:** In 2009, CMS began packaging payment for all nonpass-through implantable biologicals into payment for the associated surgical procedure. In some cases these implantable biologicals substitute for implantable nonbiologic devices (such as for synthetic nerve conduits or synthetic mesh used in tendon repair). For 2010, CMS continues to package payment for nonpass-through implantable biologicals that are surgically inserted or implanted (through a surgical incision or a natural orifice) into the body and referred to as devices.

Pass-through status is ending this year for two products. They are biologicals that are solely surgically implanted according to their FDA-approved indications. These products are described by HCPCS Level II codes C9354 Acellular pericardial tissue matrix of non-human origin (Veritas), per square centimeter, and C9355 Collagen nerve cuff (NeuroMatrix), per 0.5 centimeter length. CMS is packaging payment for HCPCS Level II codes C9354 and C9355 and assigned them status indicator N for 2010. Additionally, any new biologicals without pass-through status that are surgically inserted or implanted (through a surgical incision or a natural orifice) would be packaged in 2010.

Beginning on or after January 1, 2010, CMS will use only the device pass-through process and payment methodology for implantable biologicals that are surgically inserted or

implanted (through a surgical incision or a natural orifice) and that are newly approved for pass-through status. Implantable biological and nonbiological devices share payment methodologies during their nonpass-through payment periods, have overlapping and sometimes identical clinical uses, and have similar regulation by the FDA as devices.

9. **Evaluation and Management Coding and Payment:** There is no change to the coding or payment of clinic visits for CY 2010.

Analysis of the most recently available claims data shows a relatively lower median cost associated with level 5 Type B emergency department visits compared to the median cost of level 5 Type A emergency department visits. Using this data, CMS has modified payment for Type B emergency department visits in 2010 consistent with their median costs. CMS will pay Type B emergency department visits through the four current APCs with one new APC. APCs and the assigned HCPCS Level II codes are:

APC 0626	Level 1 Type B Emergency Visits	G0380
APC 0627	Level 2 Type B Emergency Visits	G0381
APC 0628	Level 3 Type B Emergency Visits	G0382
APC 0629	Level 4 Type B Emergency Visits	G0383
APC 0630	Level 5 Type B Emergency Visits	G0384

Level 5 Type B emergency department visits will be paid through new APC 0630. The HCPCS G-codes listed on the right are the only HCPCS codes assigned to these APCs. The title of APC 0616 has been changed to Level 5 Type A Emergency Visits to distinguish it from the new APC 0630.

CMS plans to continue to regularly reevaluate patterns of Type A and Type B emergency department visit reporting and to examine trends in cost data over time. Alternative emergency department visit APC configurations may be proposed in the future if updated data indicate that changes to the payment structure may be warranted.

10. **Transitional Pass-Through Drugs and Biologicals:** The pass-through status of six drugs and biologicals are expiring on December 31, 2009. These drugs and biologicals are:

C9354 Veritas collagen matrix, cm2
 C9355 Neuromatrix nerve cuff, cm
 J1300 Eculizumab injection
 J3488 Reclast injection
 J9261 Nelarabine injection
 J9330 Temsirolimus injection

37 drugs and biologicals will have pass-through status in 2010.

CMS continues to pay for drugs and biologicals with pass-through status at a rate of ASP+6 percent, equivalent to the rate these drugs and biologicals would receive in the physician office setting in 2010. For 2010, the difference between the ASP+6 percent and the ASP+4 for non-pass-through drugs and biologicals is the pass-through amount. CMS proposes to update pass-through payment rates on a quarterly basis during 2010 if necessary.

For purposes of pass-through payment, radiopharmaceuticals are considered drugs under OPDS and diagnostic and therapeutic radiopharmaceuticals that are granted pass-through status will be paid based on the ASP methodology. Policy-packaged drugs, biologicals, diagnostic radiopharmaceuticals or contrast agents would otherwise be packaged if the product did not have pass-through status. For these, CMS will offset pass-through payments by an amount determined to be the policy-packaged drug or the device portion of the associated clinical APC in which the drug or biological is used. Beginning in 2010, CMS will

set the associated copayment amount for pass-through diagnostic radiopharmaceuticals, contrast agents, and implantable biologicals that would otherwise be packaged if the item did not have pass-through status to zero. The separate OPPS payment for the pass-through diagnostic radiopharmaceutical, contrast agent, or implantable biological, after taking into account any applicable payment offset for the item is the item's pass-through payment, which is not subject to a copayment according to statute.

11. **Drugs, Biologicals and Radiopharmaceuticals Eligible for Separate Payment:** For CY 2010, CMS used a threshold of \$65 to be used to package drugs, biologicals and radiopharmaceuticals that are not new and do not have pass-through status. For 2010, CMS is now making a single packaging determination for a drug, rather than an individual HCPCS code, when a drug has multiple HCPCS codes describing different dosages. For CY 2010, the agency weighted average ASP+4 payments across all of the HCPCS codes that describe each distinct drug or biological to determine the mean units per day of the drug or biological in terms of the HCPCS code with the lowest dosage descriptor. CMS then estimated the estimated per day cost of each drug or biological at less than or equal to \$65 or greater than \$65.

Blood clotting factors will receive an additional furnishing fee as yet unknown. The payment amount for the furnishing fee each year is updated based on the consumer price index (CPI) and will be equal to the furnishing fee payment amount noted in the Medicare physician fee schedule (MPFS) final rule.

CMS now has five years of claims data for the oral and injectable forms of 5-HT3 antiemetic products which it exempted from packaging requirements beginning in 2005. While CMS continues to believe that use of these antiemetics is an integral part of an anticancer treatment regimen, the agency no longer feels that a specific exemption is warranted. CMS is packaging all 5-HT3 antiemetics except palonosetron hydrochloride for 2010.

There are eight drugs and biologicals that were payable in 2008, but for which there is no 2008 claims data and any other pricing information for the ASP methodology. For 2010, CMS has changed the status indicator for the eight drugs and biologicals shown below to status indicator E, not paid by Medicare when submitted on outpatient claims (any outpatient bill type), as these drugs and biologicals are not currently sold or have been identified as obsolete. If pricing information reflecting recent sales becomes available, the agency to provide separate payment for these drugs and biologicals and would assign the products status indicator K. The eight drugs and biologicals are:

- 90296 Diphtheria antitoxin
- 90581 Anthrax vaccine, sc
- 90727 Plague vaccine, im
- J0128 Abarelix injection
- J0350 Injection anistreplase 30 u
- J0395 Arbutamine hcl injection
- J1452 Intraocular Fomivirsen na
- J2460 Oxytetracycline injection

CMS continues its annual struggle with the adjustment of OPPS payments to include the acquisition and overhead related expenses, such as pharmacy services and handling costs. The panel, CMS, and MedPAC have all put forth suggestions regarding pharmacy overhead costs in hospital outpatient departments. Most of these suggestions have been rejected as too administratively burdensome.

In 2006, CMS established payment for separately payable drugs and biologicals at ASP+6 percent, which was calculated by comparing the estimated aggregate cost of separately payable drugs and biologicals in claims data to the estimated aggregate ASP dollars for

separately payable drugs and biologicals. The ASP was used as a proxy for average acquisition cost. The difference between the claims data cost and the ASP was deemed the overhead cost. This then became CMS's standard drug payment methodology. CMS determined that payment for drugs and biologicals and pharmacy overhead at a combined ASP+6 percent rate would serve as the best proxy for the combined acquisition and overhead costs of each of these products. Payment at ASP+6 percent continued in 2007.

In 2008, claims data indicated that ASP+3 percent was the appropriate payment for 2008. Since this was a big drop from 2007, CMS provided a transitional payment of ASP+5 percent for separately payable drugs and biologicals and their pharmacy overhead. Hospitals were to continue to include charges for pharmacy overhead costs in the line-item charges for the associated drugs reported on claims. For 2009, standard drug payment methodology from the final rule claims and cost report data yielded an equivalent average ASP-based payment rate of ASP+2 percent. CMS set payment rates for separately payable nonpass-through drugs and biologicals at a one-year transitional rate of ASP+4 percent.

For 2010, CMS looked at calculated overhead costs for both packaged and separately payable drugs and biologicals. Claims data reveals that the cost recorded on claims for packaged drugs and biologicals show an overhead cost of ASP+359 percent. CMS attributes pharmacy overhead cost. Claims data also reveals that the cost recorded on claims for separately payable drugs and biologicals show a negative pharmacy overhead cost of ASP-3 percent.

CMS believes that approximately one-third to one-half of the total pharmacy overhead cost currently associated with packaged drugs and biologicals is a function of both charge compression and the choice of an annual drug packaging threshold. The agency believes that approximately \$150 million of the estimated overhead for packaged drugs and biologicals should be attributed to separately payable drugs and biologicals, a more appropriate allocation of drug and biological overhead. CMS has reduced the cost of packaged drugs and biologicals included in the payment for procedural APCs by \$150 million. Payments for separately payable drugs and biologicals have been increased by \$150 million. This limited redistribution of pharmacy overhead cost occurs only from one group of drugs and biologicals to another group of drugs and biologicals maintaining the estimated total cost of drugs and biologicals.

The adoption of a transitional payment rate of ASP+4 percent based on a limited adjustment of pharmacy overhead would base OPPS payment upon the best available proxy for the average acquisition and pharmacy overhead costs of separately payable drugs and biologicals. CMS will continue to examine the issue of pharmacy overhead costs and hopes that hospitals examine administrative changes that could result in their submission of more accurate data.

12. **Brachytherapy Payment:** CMS used the 2008 claims data to set the 2010 payment rates for brachytherapy sources. Using 2008 claims data, a full year of claims data for each of the separately payable sources, including iodine, palladium, and cesium sources that have stranded and non-stranded configurations. CMS will pay for the stranded and non-stranded NOS codes, HCPCS Level II codes C2698 and C2699, at a rate equal to the lowest stranded or non-stranded prospective payment rate for such sources, respectively, on a per source basis.

Consistent with other OPPS policy, brachytherapy sources with prospectively set payment rates would be subject to scaling for purposes of budget neutrality, and could receive outlier payments if the costs of furnishing brachytherapy sources meet the criteria for outlier payment. Additionally, the implementation of prospective payments provides the opportunity for hospitals to receive additional payments in 2010 under certain circumstances through the

7.1 percent rural SCH adjustment.

13. **Kidney Disease Education Services:** The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, Public Law 110-275, added coverage of kidney disease education (KDE) services as a Medicare Part B benefit for Medicare beneficiaries diagnosed with stage IV chronic kidney disease (CKD) defined as kidney damage with a severe decrease in glomerular filtration rate (GFR) quantitatively defined by a GFR value of 15-29 ml/min/1.73 m², using the Modification of Diet in Renal Disease (MDRD) Study formula. As there are currently no agreed upon accepted clinical guidelines that describe the stage IV patients who would eventually require dialysis or a kidney transplant, CMS will cover all stage IV patients. This is effective for services furnished on or after January 1, 2010. The law also defined “kidney disease education services” and specified who may furnish these services as a “qualified person.” The KDE benefit is being implemented mainly through the 2010 Medicare physician fee schedule (MPFS) final rule.

A qualified person is defined as a physician; or a physician assistant, nurse practitioner, or clinical nurse specialist who furnishes services for which payment may be made under the MPFS schedule. The definition of a qualified person for this benefit includes certain rural providers of services, such as hospitals, critical access hospitals (CAHs), skilled nursing facilities (SNFs), home health agencies (HHAs), comprehensive outpatient rehabilitation facilities (CORFs), and hospices. MIPPA states that a qualified person does not include a renal dialysis facility or a provider of services (other than a rural provider of services previously described). CMS defines a provider of services in a rural area as a hospital, CAH, SNF, CORF, HHA, or hospice that is physically located in a rural area or a hospital or CAH that is reclassified from urban to rural status.

CMS has established two new HCPCS Level II G-codes to describe KDE services. HCPCS Level II code G0420 is defined as Educational services related to the care of chronic kidney disease; individual per session, per hour, face-to-face, and G042 is defined as Educational services related to the care of chronic kidney disease; group, per session, per hour, face-to-face. These codes have been given an OPSI of A signifying that these services, when covered, would be paid under a payment system other than OPPS, specifically the MPFS. Additional information is available in the 2010 MPFS final rule published in the **Federal Register** November 25, 2009.

14. **Rehabilitation Services:** MIPPA extended Medicare coverage and payment for pulmonary rehabilitation (PR), cardiac rehabilitation (CR), and intensive cardiac rehabilitation (ICR) services furnished to beneficiaries with chronic obstructive pulmonary disease and certain other conditions effective January 1, 2010. These services can be provided in a physician's office, in a hospital on an outpatient basis, or in other settings deemed appropriate by CMS. Coverage and payment under the MPFS for a CR, ICR, or PR program is discussed the 2010 MPFS final rule. Finalized 2010 OPPS payment for CR, ICR, or PR programs furnished to hospital outpatients is discussed below.

Pulmonary Rehabilitation: MIPPA has added pulmonary rehabilitation (PR) as a Medicare benefit. Previously, the individual components of PR were reported and coverage was at the discretion of the Medicare contractor. Effective January 1, 2010, a PR comprehensive program will be covered for patients with moderate (Stage II) to very severe COPD (Stage IV) when referred by the physician treating the chronic respiratory disease. Moderate, severe, and very severe COPD is defined using the GOLD classification II, III, and IV respectively.

HCPCS Level II code G0424, Pulmonary rehabilitation, including aerobic exercise (includes monitoring), per session, per day, has been created for hospitals to report and bill for the services furnished under a PR program. Hospitals are to report sessions lasting a minimum

of 60 minutes each, generally for two to three sessions of PR per week. No more than one session per day would be allowed as participants have significant respiratory compromise.

The PR service described by G0424 is a new comprehensive service. CMS has simulated a “per session” hospital median cost of approximately \$50 using claims data for the existing pulmonary therapy HCPCS Level II G-codes, associated assessments, and applicable tests. PR is being assigned to a new APC 0102, Level II Pulmonary Treatment. (APC 0078 has been renamed Level III Pulmonary Treatment without any change in its configuration.) The existing pulmonary therapy HCPCS Level II G-codes codes G0237, G0238, and G0239 will continue to be used for the respiratory services previously allowed by local contractors for other medical conditions under other part B benefit categories.

Cardiac and Intensive Cardiac Rehabilitation Programs: Currently, cardiac rehabilitation (CR) services furnished by hospitals are reported using CPT codes 93797 and 93798. Each session must be a minimum of 60 minutes and patients must participate in a minimum of two CR sessions a week, with a maximum of two CR sessions a day.

MIPPA allows intensive cardiac rehabilitation (ICR) services in a series of 72 one-hour sessions, up to six sessions per day, over a period of up to 18 weeks. For the 2010 OPSS, HCPCS Level II codes G0422 will be used for Intensive cardiac rehabilitation; with or without continuous ECG monitoring, with exercise, per hour, per session, and G0423 will be used for Intensive cardiac rehabilitation; with or without continuous ECG monitoring, without exercise, per hour, per session.

Only hospitals that have an ICR program that has received a designation as a qualified ICR program would report these proposed new HCPCS G-codes. Hospitals will be qualified through a process to be detailed in an NCD. Each session of ICR must be a minimum of 60 minutes and that each day ICR items and services are provided to a patient, aerobic exercises along with other exercises must be included.

All CR and ICR codes have been assigned to APC 0095, Cardiac Rehabilitation with a status indicator of S. Both CR and ICR programs consist of exercise, cardiac risk factor modification, psychosocial assessment, outcomes assessment and other services. Although an ICR program may perform more sessions per day for a patient than may be provided in than a CR program, CMS believes the hospital costs for a single session would be similar. OPSS payment for CR and ICR would be provided on a per-session basis.

Physician Supervision of CR, ICR and PR: MIPPA includes requirements for immediate and ongoing physician availability and accessibility for both medical consultations and medical emergencies at all times items and services are being furnished under CR, ICR, and PR programs. Direct supervision, as defined in the regulations, is the physician must be present and immediately available where the services are being furnished. The physician must also be able to furnish assistance and direction throughout the performance of the services, which would include medical consultations and medical emergencies.

For CR, ICR, and PR services provided to hospital outpatients, direct physician supervision is the standard set forth in the April 7, 2000 OPSS final rule for supervision of hospital outpatient therapeutic services covered and paid by Medicare in hospitals and provider-based departments of hospitals. For CR, ICR, and PR services furnished in off-campus provider-based departments of the hospital, direct supervision would continue to mean that the physician must be in the off-campus department and immediately available to furnish assistance and direction throughout the performance of the procedure, which would include medical consultations and medical emergencies.

FOR FURTHER INFORMATION

If you have questions regarding these proposed OPPS changes, please contact our Client Services Department at 1-800-999-DRGS (3747). Be sure to check the Ingenix Web site for up-to-date information and additional ***Industry Insights*** on coding issues. You will find ***Industry Insights*** under "News & Events" (<http://www.ingenix.com/News/Industnews/>).